Testimony submitted for the April 3, 2014 Legislative Hearing
on the"Helping Families in Crisis" Act of 2013 (H.R. 3717)

by the National Coalition for Mental Health Recovery

The National Coalition for Mental Health Recovery is an organization of people in recovery from serious mental illnesses. Our Coalition, with member organizations in more than 30 states, is a national voice of people who have been most severely affected by mental illness. We want to make sure our voice is heard and understood in Washington on the decisions that affect our lives and health, and in particular on HR 3717.

We agree with Representative Tim Murphy, the sponsor of HR 3717, that the current mental health system is inadequate to fully meet the needs of persons with psychiatric disabilities. However, HR 3717 will have serious unintended consequences. It would do away with many significant advances made in mental health care in the last 30 years and place federal and state governments at high risk for litigation under the Americans with Disabilities Act and the Supreme Court's *Olmstead* decision. No other population of persons with disabilities is subject to the civil rights violations that will be implemented by the provisions of this bill. Furthermore, the criteria proposed for coercing people into treatment, especially mandated medication usage, will usher in a new level of government intrusion into people's lives. Finally, HR 3717 disregards the body of research that clearly documents the negative impacts of forced treatment on long-term outcomes.

The bill's provisions, if adopted, would lead to increased discrimination and stigma against people with psychiatric disabilities. This is based on a fallacious belief that people with psychiatric disabilities are more prone to violence than other populations. This belief is not borne out by a significant body of evidence showing that they are more often victims of violence, not perpetrators.

1. This proposed legislation eliminates many hopeful, innovative initiatives that are already shown to promote recovery from mental health problems through the use of evidence-based, voluntary, peer-run programs and family services and supports. Dr. Daniel Fisher, Ph.D., M.D. states: "These services have a proven track record in helping people stay out of the hospital and live successfully in the community. Because hospitalization is far more expensive and has far worse outcomes than community-based services, this bill would cost more money for worse outcomes." Provisions that arbitrarily cap funding of SAMHSA Programs of Regional and National Significance and terminate all programs not specifically authorized in statute should be eliminated.

2. The bill attacks the Substance and Mental Health Services Administration (SAMHSA), the only federal agency which has adopted the recovery model. SAMHSA's alignment with recovery-oriented, community-based approaches

is rooted in a growing evidence base indicating that recovery approaches lead to better long-term outcomes for individuals with psychiatric disabilities and their families. Recent studies supported by the Foundation for Excellence in Mental Health Care and other funders are showing definitively that hope is a reasonable expectation for people with even the most significant psychiatric disabilities, such as people diagnosed with schizophrenia. These studies (Harrow, Wunderink, Harding, et al) can be provided at the request of any legislator or committee.

3. The bill proposes to essentially eliminate SAMHSA as it currently exists and institute yet another federal bureaucracy with yet another Assistant Secretary and Department. This proposition is wasteful of taxpayer dollars. The best way to reduce costs and to lower rates of disability is to advance initiatives and programs that promote recovery and wellness, which are already among SAMHSA's strategic priorities.

4. Key provisions of this proposed legislation violate *Olmstead v. L.C.* (1999) which requires treatment services to be delivered in the "least restrictive environment." Many states are already reeling from costly challenges to their current systems of care, and this will only increase the burden of both state and federal governments. The US Supreme Court has clearly laid the legal foundation to move away from institutional and coercive care, and people with disabilities deserve better than warehousing.

5. Research and field experience strongly indicates that when people know or believe they are going to be subject to coercive treatments, they will become even more resistant and try to avoid services as much as possible. These interventions are largely experienced as humililating, dehumanizing, and traumatizing to people with psychiatric disabilities. Provisions promoting court-ordered treatment will result in the exact opposite of the intentions of the bill.

   We reject provisions of this bill to elevate into Federal policy the criteria for involuntary psychiatric commitment and to withhold formulaic mental health block grant funds from states unless they change commitment criteria in their own state laws.

   We reject provisions throughout this bill that fund and promote use of involuntary outpatient commitment (IOC). Federal mental health policy should incentivize timely voluntary services and supports in the community that prevent crisis and deterioration and promote recovery. Involuntary outpatient commitment unnecessarily criminalizes people in crisis as a condition of receiving intensive services they needed to receive far sooner to avert crisis. It imposed additional coercion and trauma as a condition of receiving help, and drives people from services. It is costly, controversial and is not an evidence-based practice.

6. Finally, this bill would eviscerate the rights and privacy protections for people with mental illness, enshrined in the federally mandated Protection and Advocacy (P&A) System, which is the largest provider of legal advocacy services to people with disabilities in the United States. The bill singles out one group of people with disabilities, denies access to protection and advocacy, and compromises their rights. At a time when people with psychiatric disabilities are most likely to be misunderstood so that their American civil rights are violated, HB 3717 will create a huge litigation burden on federal and state governments. Most importantly, the dissolution of civil rights protections will threaten the hope and well-being of people and families struggling to regain their lives.

Provisions of specific concern include:

Section 102 – inter-agency serious mental illness coordinating committee: the bill would require nine non-federal members, including one individual who lives with a serious mental illness and one family member. Nonfederal members must also include a psychiatrist, a psychologist, a law enforcement officer, a judge with experience in assisted outpatient treatment, and a correctional officer.
Modification: There should be at least two persons with psychiatric disabilities and two family members among the committee members.

Section 1151 – SAMHSA may only finance programs that rely on evidence-based practices (EBPs).
Modifications: In addition to EBPs, there need to be provisions for funding innovative programs that further the vision of the New Freedom Commission and Institute of Medicine (IOM) report of 2006. Treatment and policy formation should be guided by the goals of recovery and continued self-determination of people with psychiatric disabilities and their families.

Section 1152 – SAMHSA may not finance any project that is not explicitly authorized by statute.
Modification: This provision should be dropped, as it also would eliminate any of the innovative programs developed by persons with disabilities and their families since the original authorization of SAMHSA.

Section 1102 – SAMHSA advisory councils must have at least 50% members who have a medical degree, an equivalent doctoral degree in psychology, or are licensed mental health professionals.
Modification: SAMHSA advisory councils should continue to reflect a collaborative approach, including licensed mental health professionals, certified peer specialists, persons with disabilities, and their families.

Section 1103 - requires that any SAMHSA review panel have at least 50% members who have a medical degree, an equivalent doctoral degree in psychology, or licensed mental health professionals.

Modification: This section should be reworded to say that any SAMHSA review panel should demonstrate expertise in the subject matter of the grant or contract under consideration.

Section 1112 - requires all proposed projects of regional or national significance to be submitted for prior review by House and Senate committees.
Modification: This would be burdensome and the subject matter is outside the expertise of House and Senate Committees; thus the provision should be dropped.

HB 3717 represents fear-based policy, and moves the United States in exactly the wrong direction. What people with disabilities, and their families, deserve are policies rooted in hope, recovery, wellness, and effectiveness. Increased resources for now well-researched early psychosis intervention programs, such as Finland's Open Dialogue, evidence-based prevention services, community and peer supports, would dramatically increase the availability of cost-effective, community-based services. We need to move forwards, not backwards, where HB 3717 would take us as a nation.

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